St. Jude Children's Research Hospital
ALSAC • Danny Thomas, Founder

Certification of Health Care Provider
(Family and Medical Leave Act of 1993)

SECTION I: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section I before giving this form to your medical provider. The FMLA permits St. Jude Children's Research Hospital (SJCRH) to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition or a family member (parent, spouse, and child). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. **The employee must return the completed form to HR Benefits within 15 calendar days from date of receipt.**

Employee's name: _____

Employee's job title: _____ Regular work schedule: _____

Check if job description is attached: _____

_____ Own serious health condition **_____ To care for family member**

Name of family member for whom you will provide care:_____

Relationship of family member to you: _____

If family member is your son or daughter, date of birth:_____

Describe care you will provide to your family member and estimate leave needed to provide care:

_____

_____

_____

If additional information is needed, may we contact the physician? YES___ NO ___

_____ _____
Employee Signature Date

SECTION II: For Completion by the HEALTH CARE PROVIDER INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested leave under the FMLA or the employee listed above has requested leave under the FMLA to care for your patient. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. **Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage.** Limit your responses to the condition for which the employee is seeking leave. Please be sure to sign the form on the last page.

Provider's name and business address: _____

Type of practice / Medical specialty: _____

Telephone: (_____)_____ Fax:(_____)_____

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

   Probable duration of condition: _____

   Mark below as applicable:

   Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? ___No ___Yes. If so, dates of admission:

   _____

   Date(s) you treated the patient for condition: _____

   Will the patient need to have treatment visits at least twice per year due to the condition? ___No ___ Yes

   Was medication, other than over-the-counter medication, prescribed? ___No ___Yes

   Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)? ___No ___Yes. If so, state the nature of such treatments and expected duration of treatment:

   _____

   _____

2. Is the medical condition pregnancy? ___No ___Yes. If so, expected delivery date: _____

3. Use the information provided by the employer in Section I to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions.

   Is the employee unable to perform any of his/her job functions due to the condition: ____ No ____ Yes

   If so, identify the job functions the employee is unable to perform:

   _____

4. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

_____

_____

_____

IF CARE IS FOR A FAMILY MEMBER, PLEASE GO TO PART C

PART B: AMOUNT OF LEAVE NEEDED

5. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? ___No ___Yes

   If so, estimate the beginning and ending dates for the period of incapacity: _____

6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? ___No ___Yes

   If so, are the treatments or the reduced number of hours of work medically necessary? ___No ___Yes

   Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

   _____

   Estimate the part-time or reduced work schedule the employee needs, if any:

   _____ hour(s) per day; _____ days per week from _____ through _____

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ____No ___Yes

   Is it medically necessary for the employee to be absent from work during the flare-ups?

   ____ No ____Yes . If so, explain:

   _____

   _____

   Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

   Frequency: _____ times per _____ week(s) _____month(s)

   Duration: _____ hours or _____ day(s) per episode

PART C: AMOUNT OF CARE NEEDED: When answering these questions, keep in mind that your patient's need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care:

8. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery? ___No ___Yes

   Estimate the beginning and ending dates for the period of incapacity: _____

   During this time, will the patient need care? ___ No ___Yes

   Explain the care needed by the patient and why such care is medically necessary:

   _____

   _____

9. Will the patient require follow-up treatments, including any time for recovery? ___No ___Yes

   Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

   _____

   Explain the care needed by the patient, and why such care is medically necessary: _____

   _____

10. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery? ___No ___Yes

    Estimate the hours the patient needs care on an intermittent basis, if any:

    _____ hour(s) per day; _____ days per week from _____ through _____

    Explain the care needed by the patient, and why such care is medically necessary:

    _____

    _____

11 Will the condition cause episodic flare-ups periodically preventing the patient from participating in

   normal daily activities? ____No ____Yes

   Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

   Frequency: _____ times per _____ week(s) _____ month(s)

   Duration: _____ hours or ___ day(s) per episode

   Does the patient need care during these flare-ups? ____No ____Yes

Explain the care needed by the patient, and why such care is medically necessary: _____

_____

_____

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

_____

_____

_____

_____

_____

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_____ _____

Signature of Health Care Provider **Date**